

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1369
Registrar's No. 329

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County. Jackson
(b) City or town. Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community. 10 years
years, months or days)

3. (a) PRINT FULL NAME. PAT RIDER

3. (b) If veteran, name war. None 3. (c) Social Security No. 487-16-7237

4. Sex. Male 5. Color or race. White 6. (a) Single, widowed, married, divorced. Single

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years

7. Birth date of deceased. ? (Month) ? (Day) 1883 (Year)

8. AGE: Years 58 Months Days If less than one day hr. min.

9. Birthplace. Texas (City, town, or county) (State or foreign country)

10. Usual occupation. Cashier

11. Industry or business. Thompson Restaurants

12. Name. Unknown

13. Birthplace. Unknown (City, town, or county) (State or foreign country)

14. Maiden name. Unknown

15. Birthplace. Unknown (City, town, or county) (State or foreign country)

16. (a) Informant. Record Clerk

(b) Address. K. C. General Hosp. #1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 28 41 (Month) (Day) (Year)

(c) Place: burial or cremation. Greenlawn

18. (a) Signature of funeral director. Wailert Funeral Home

(b) Address. 2332 Monitor Place, K. C. Mo.

19. (a) Jan 22 1941 (Date received local registrar) (b) M. M. Cronin (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Jackson 48
(c) City or town. Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 312 East 13th St. 1
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20th
year 1941 hour 10 minute 35 A. M.

21. I hereby certify that I attended the deceased from 1-1-41, 19, to 1-20-41, 19;
that I last saw him alive on 1-20-41, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death. Cord Bladder

Due to Syphilis of the central nervous system

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy. None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).
(b) Date of occurrence.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury. 0

23. Signature Dr. R. Thron (M. D. or other)
Address Med. Dir. K. C. Gen. Hospital Date signed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.